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CHAPTER IV
SURGERY: MUSCULOSKELETAL SYSTEM
CPT CODES 20000-29999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter IV
Surgery: Musculoskeletal System
CPT Codes 20000 - 29999

A. Introduction

The general guidelines regarding correct coding apply to the CPT codes in the range of 20000-29999. Specific issues unique to this section of CPT are clarified in the following guidelines.

B. Anesthesia

Anesthesia administered by a physician performing a procedure is included in the procedure. Accordingly, injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not to be separately reported. Specifically, the CPT codes 20526-20553 (therapeutic injection and injections of tendon sheath, ligament, muscle) are not to be used as an injection code to provide local anesthesia for a surgical, closed, manipulative or other procedure; this is not the intent of the CPT code. Many code pair edits are included in the Correct Coding Initiative based on this policy. When separate anatomic areas are being treated, the appropriate anatomic modifier or the -59 modifier should be used to indicate this situation.

C. Biopsy

In accordance with the sequential procedure policy, when a biopsy is performed in conjunction with any excision, destruction, removal, repair or internal fixation procedure, the biopsy procedure is not to be separately coded assuming a diagnosis has already been established which makes the excision, destruction, removal, repair or fixation procedure medically necessary. If the biopsy is performed at a different site and represents a significant, separately identifiable service, a biopsy service can be reported. For example, if a patient presents with an upper extremity fracture and, during an internal fixation procedure, it is determined to be medically reasonable to perform a bone biopsy of the iliac crest while under the same anesthetic, a separate service for a bone biopsy, with the -59 modifier, could be reported. If, however, through the same incision, a biopsy of the humerus was obtained, this service is not to be separately reported. In the circumstance where the decision to perform the more comprehensive procedure (excision, destruction, removal, repair or fixation procedure) is dependent on the

results of the biopsy procedure, the biopsy procedure may be separately reported.

Additionally, in accordance with the sequential procedure policy, when an arthroscopic procedure is followed by an open procedure at the same session, only the column 1 service is reported; generally, this would be the open procedure. If an arthroscopic service is performed at one site and an open procedure is performed at another, the arthroscopic service is reported with a modifier indicating that these services were performed at different anatomic sites (e.g. -RT or -LT modifier, -59 modifier, etc.)

D. Fractures

1. In general, the application of external immobilization devices (including casts) at the time of a procedure also includes removal services during (or after) the post-procedure period. CPT codes have been included for removal and modification of external fixation devices by a physician other than the physician who initially applied the device. These codes are not to be reported by the same entity (physician, practice, group, etc.) that performed the initial application service. When the initial service includes only an evaluation and management service and does not include a definitive procedure (e.g. surgical repair, reduction of a fracture or joint dislocation) the cast/strapping may be separately reported from the evaluation and management service. When the only service rendered at a visit is cast or strapping application, a separate evaluation and management service should not be reported unless separate evaluation/management services are performed that satisfy the evaluation and management guidelines. CPT codes describing modification or removal of casts (e.g. 29700-29750) are not to be reported when these modifications are performed at the same session as the primary (open or closed) procedure.

2. Different codes have been created for removal of internal fixation devices as a separate procedure and modification/removal of these devices in conjunction with other procedures. When a superficial or deep implant (buried wire, pin, rod) requires a surgical procedure to remove (e.g. CPT code 20670), and it is performed as a separate procedure, this service may be reported. On the other hand, when the service is necessary to accomplish another procedure involving the same area, it is not to be reported separately.

3. In accordance with the general policy on most extensive procedures, when a fracture requires closed reduction followed by

open reduction at the same patient encounter (e.g. inability to accomplish the closed reduction), only the open reduction service is reported.

4. When interdental wiring (e.g. CPT code 21497) is necessary in the treatment of facial (or other) fractures, as part of a facial reconstructive surgery, or arthroplasty, it is included as part of the service; accordingly, a separate service using the CPT code 21497 is not reported. If reported with other head and neck procedure codes, it should be coded with the -59 modifier, indicating a separate distinct service was performed. The medical record should reflect the nature of the separately identifiable service.

5. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion or accomplish fracture reduction as part of another related procedure, the corresponding manipulation code (e.g. CPT codes 22505, 23700, 27275, 27570, 27860) is not to be separately reported.

6. CPT codes 22840-22848, 22851 (spinal instrumentation) are to be reported with only CPT codes 22325, 22326, 22327, 22548-22812 for fracture, dislocation, or arthrodesis of the spine.

E. General Policy Statements

1. When a tissue transfer procedure (e.g. graft) is described in the principal procedure code, a separate service is not reported for performing the tissue transfer service necessary to complete the procedure.

2. In situations where monitoring of interstitial fluid pressure is routinely performed as part of the postoperative care (e.g. distal lower extremity procedures with risk of anterior compartment compression), a separate code for monitoring of interstitial fluid pressure (e.g. CPT code 20950) should not be reported.

3. When electrical stimulation is used to aid bone healing, the appropriate bone stimulation codes (CPT codes 20974-20975) should be reported; the codes for nerve stimulation (CPT codes 64550-64595) are inappropriate for this service. If a neurostimulator is medically necessary for other indications (e.g. pain control), a separate service is reported, however, the -59 modifier should be attached indicating that this service is distinct in that it represents treatment of different symptoms;

accordingly the medical record should reflect the indication for the nerve stimulator. In addition, CPT codes 97014 and 97032 (physical medicine for electrical stimulation) are not to be reported in conjunction with the above listed codes by the surgeon.

4. Routinely, exploration of the surgical field is performed during a surgical session; codes describing independent exploratory services are not to be reported when a more comprehensive procedure is being performed in the same area. Specifically, an exploration code such as CPT code 22830 (exploration of spinal fusion) is not reported with other procedures involving the spine unless performed at a different site/different incision from the other procedure (s). If, for example, a cervical spine procedure was being performed, and, at the same operative session, a lumbar fusion was explored through a separate incision, the CPT code 22830-59 could be reported assuming the requirement for medical necessity was satisfied.

5. Debridements (CPT codes 11040-11042, and 11720-11721) are included in the surgical procedures conducted on the musculoskeletal system when debridement of tissue is in the immediate surgical field of other than fractures and dislocations. If, however, tissue debridement is necessary for a more extensive area (e.g. concurrent soft tissue damage due to trauma), the debridement codes can be reported. In open fractures and/or dislocations, debridement of tissue due to the fracture should be separately reported using the CPT codes 11010-11012.

6. Grafts, such as CPT codes 20900-20924, are only to be separately reported if the major procedure code description does not include graft in its definition.

7. The CPT code 20926 is a general code for tissue grafting (e.g. paratenon, fat, dermis) to be used when the primary procedure does not include grafting and when another graft code does not more accurately describe the nature of the grafting procedure being performed. Accordingly, it should not be used with codes in which the graft is already listed as a part of the procedure or with other grafting codes (see Chapter III for other graft codes).

8. CPT codes 29874 (Surgical knee arthroscopy for removal of loose body or foreign body) and 29877 (Surgical knee arthroscopy for debridement/shaving of articular cartilage) should not be reported with other knee arthroscopy codes (29871-29889). Report G0289 (Surgical knee arthroscopy for removal of loose body,

foreign body, debridement/shaving of articular cartilage at the time of other surgical knee arthroscopy in a different compartment of the same knee).

9. Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475 and 90780 describe services that may be utilized for postoperative pain management. The services described by these codes may be reported only if performed for purposes unrelated to the postoperative pain management.

10. Medicare Anesthesia Rules prevent separate payment for anesthesia when provided by the physician performing a medical or surgical service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 90780) should not be reported when these services are related to the delivery of an anesthetic agent.